

**CITY OF SAN ANTONIO**  
**DANGEROUS/AGGRESSIVE DOG AFFIDAVIT**  
4710 State Highway 151 San Antonio, Texas 78227

**PLEASE TYPE  
OR PRINT**

Press "Tab" Button to  
Move Between Fields

**Please place all information on the front of this document.  
Do not write on the back of this paper or on your own paper.**

**APPLICANT INFORMATION**

<b>Name:</b>		<b>DOB:</b>	<b>Driver's License No:</b>
<b>Street Address:</b>		<b>City/State:</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Email:</b>		
<b>Did anyone other than you witness the incident?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please fill out "Witness Information" section below.</i>			

**WITNESS INFORMATION (If Available)**

<b>Name:</b>		<b>Phone:</b>
<b>Street Address:</b>	<b>City/State:</b>	<b>Zip:</b>
Additional witnesses may be listed in the last section.		

**INCIDENT INFORMATION**

<b>Where did the incident happen?</b>		
<b>When did the incident happen?</b>	<b>Date:</b>	<b>Time:</b>
<b>Did the attack occur on the dog owner's property?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Was the dog owner present?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If no, where did the attack happen? (Address or Street block)</b> Sidewalk <input type="checkbox"/> Street <input type="checkbox"/> Driveway <input type="checkbox"/> Front yard <input type="checkbox"/> Back yard <input type="checkbox"/> Easement <input type="checkbox"/> Intersection <input type="checkbox"/> Inside Home <input type="checkbox"/>		
<b>Did the attack occur in a fenced yard or enclosed area?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Did you fear you or another person would be attacked and that the dog would injure you or them?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>If yes, briefly describe how or why?</b>  		
<b>Do you believe that you (or bite victim, if not you) did anything to cause the dog to attack?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Please describe what you were doing at the time of the attack:</b>  		

**MEDICAL INFORMATION – HUMAN VICTIM**

<b>Did you receive any injuries as a result of this incident?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, complete this section. If no, skip to next section.</i>	
<b>Did you receive medical treatment at a clinic or hospital?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Hospital or Clinic where you were treated:</b> Name: Address: Phone Number:	<b>Can you provide documentation or pictures?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Are you willing to provide Animal Care Services with Medical Records?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If yes, please describe the location and severity of your injury(ies):</b>  	
<b>Name of Attending Physician:</b>	
<b>Address:</b>	



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**ADDITIONAL WITNESSES:**

NAME	ADDRESS	PHONE NUMBER

**ADDITIONAL DOGS INVOLVED OR POSSIBLY INVOLVED**

NAME	BREED OR TYPE	COLOR	OWNER (If Known)

**ADDITIONAL INFORMATION RELEVANT TO THE CASE**


**SIGNATURE:** \_\_\_\_\_  
(Must be Signed in the Presence of a Texas Notary Public)

**DATE:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

STATE OF TEXAS  
COUNTY OF BEXAR

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20 \_\_\_\_.

Notary Signature: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**OFFICE USE ONLY:**

RECEIVED BY	DATE RECEIVED	REVIEWED BY	DATE REVIEWED
<b>OUTCOME:</b> APPROVED <input type="checkbox"/> REJECTED <input type="checkbox"/>		<b>REASON IF REJECTED:</b>	
<b>Type of follow up:</b> Dangerous <input type="checkbox"/> Aggressive <input type="checkbox"/> SBI <input type="checkbox"/> ABD <input type="checkbox"/> ABDD <input type="checkbox"/> ADW/ABI <input type="checkbox"/> Other:			